



Please Review and Sign Below

Consent of Treatment, Authorization to Release Information, Billing Disclosures/Financial Responsibility and No Show Policy:

Patient Name: _____

I hereby authorize 360 Balance & Dizziness through its appropriate personnel, to furnish medical care and treatment to me, or the above-named patient, considered necessary and proper in diagnosing or treating my/his/her physical condition. Such services may be offered onsite or online via telerehabilitation/e-health services. I further authorize 360 Balance & Dizziness to release to appropriate agencies, any information acquired in the course of my or the above-named patient's examination and treatment necessary to secure payment for services provided. I acknowledge that the Notice of Privacy Practices is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

At 360 Balance & Dizziness, our mission is to value every individual and meet the healthcare needs of patients and their families that suffer from dizziness, balance and/or hearing disorders. The service you have elected to participate in implies a financial responsibility on your part. You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible/coinsurance as determined by your contract with your insurance carrier whether services are rendered in-person or online. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. If collection for this invoice is placed in the hands of an attorney, attorney fees equal to 30% of the total invoice price shall be due and owing. If any legal action is required, it is agreed that the venue for such shall be in Travis County, Texas.

I have read the above regarding my financial responsibility to 360 Balance & Dizziness for providing services to the above-named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to 360 Balance & Hearing. I agree to pay 360 Balance & Dizziness the full and entire amount of all bills incurred by me or the above-named patient, if applicable, any amount due after payment has been made by my insurance carrier.

I hereby authorize 360 Balance & Dizziness to furnish information to insurance carriers and doctors concerning my illness and treatments, by fax or mail.

I hereby authorize 360 Balance & Dizziness to disclose my health information that is directly related to my current treatment at 360 Balance & Dizziness to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received. Such persons involved in your care may include: spouse, children, blood relatives, roommates, boyfriends/ girlfriends, domestic partners, neighbors and colleagues.

Name: _____ Relationship: _____

There is a \$75 no-show/late-cancellation fee for physical therapy appointments and a \$100 no-show/late-cancellation fee for audiology appointments. All appointments must be canceled by 5 p.m. of the previous day (or by 3 p.m. on Friday for a Monday appointment), to avoid charges for a no-show or late cancellation. After-hour messages regarding cancellations may be left at 512-345-4664. Insurance will not cover charges for no-show/late-cancellation or eligibility fees. I acknowledge that I have read and understand the No Show Policy.

Signature: _____ **Date:** _____

Note: Please check ONE of the following options.

- By signing below, I consent to both onsite (in-person) and online (telerehabilitation) services.
- Be signing below, I consent to onsite (in-person) services only.
- Be signing below, I consent to online (telerehabilitation) services only.

Signature: _____ (relationship to patient: self guardian other: _____)

Date: _____

**Health Insurance
Portability & Accountability Act**

The Health Insurance Portability and Accountability Act (HIPM) provide rights and protections for participants and beneficiaries in group health plans. HIPM includes protections for coverage under group health plans that limit exclusions for preexisting conditions; prohibit discrimination against employees and dependents based on their health status; and allow a special opportunity to enroll in a new plan to individuals in certain circumstances. HIPM may also give you a right to purchase individual coverage if you have no group health plan coverage available and have exhausted COBRA or other continuation coverage.

HIPAA Protects Workers and Their Families By

- Limiting exclusions for preexisting medical conditions (known as preexisting conditions)
- Providing credit against maximum preexisting condition exclusion periods for prior health coverage and a process for providing certificates showing periods of prior coverage to a new group health plan or health insurance issuer
- Providing new rights that allow individuals to enroll for health coverage when they lose other health coverage, get married or add a new dependent
- Prohibiting discrimination in enrollment and in premiums charged to employees and their dependents based on health status-related factors
- Guaranteeing availability of health insurance coverage for small employers and renewability of health insurance coverage for both small and large employers
- Preserving the states' role in regulating health insurance, including the states' authority to provide greater protections than those available under federal law

Preexisting Condition Exclusions

- The law defines a preexisting condition as one for which medical advice, diagnosis, care, or treatment was recommended or received during the 6-month period prior to an individual's enrollment date (which is the earlier of the first day of health coverage or the first day of any waiting period for coverage)
- Group health plans and issuers may not exclude an individual's preexisting medical condition from coverage for more than 12 months (18 months for late enrollees) after an individual's enrollment date
- Under HIPM, a new employer's plan must give individuals credit for the length of time they had prior continuous health coverage, without a break in coverage of 63 days or more,

thereby reducing or eliminating the 12-month exclusion period (18 months for late enrollees)

Creditable Coverage

- Includes prior coverage under another group health plan, an individual health insurance policy, COBRA, Medicaid, Medicare, CHAMPUS, the Indian Health Service, a state health benefits risk pool, FEHBP, the Peace Corps Act, or a public health plan

Certificates of Creditable Coverage

- Certificates of creditable coverage must be provided automatically and free of charge by the plan or issuer when an individual loses coverage under the plan, becomes entitled to elect COBRA continuation coverage or exhausts COBRA continuation coverage. A certificate must also be provided free of charge upon request while you have health coverage or anytime within 24 months after your coverage ends
- Certificates of creditable coverage should contain information about the length of time you or your dependents had coverage as well as the length of any waiting period for coverage that applied to you or your dependents
- For plan years beginning on or after July 1, 2005, certificates of creditable coverage should also include an educational statement that describes individuals' HIPM portability rights. A new model certificate is available on EBSAs Web site at www.dol.gov/ebsa/.
- If a certificate is not received, or the information on the certificate is wrong, you should contact your prior plan or issuer. You have a right to show prior creditable coverage with other evidence - like pay stubs, explanation of benefits, letters from a doctor - if you cannot get a certificate

Special Enrollment Rights

- Are provided for individuals who lose their coverage in certain situations, including on separation, divorce, death, termination of employment and reduction in hours. Special enrollment rights also are provided if employer contributions toward the other coverage terminates
- Are provided for employees, their spouses and new dependents upon marriage, birth, adoption or placement for adoption

By signing below, I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

Signature: _____ Date: _____



360 Balance and Dizziness
4601 Spicewood Springs Road
Building 2, Suite 100
Austin, TX 78759
512-345-4664

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Consent to Video-record and Authorization for Use and Disclosure

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I do hereby acknowledge, give consent, and agree that 360 Balance and Dizziness, 360 Neuro Health, Interacoustics, its employees, or agents have the right to take photographs, video recordings, or digital recordings of myself. This consent includes but is not limited to a video recording a VNG test. They may use these in any and all media, now or hereafter, for the purpose of marketing, test analysis, vestibular research, and vestibular education.

I do hereby release to 360 Balance and Dizziness, 360 Neuro Health, Interacoustics, its agents, and employees all rights to exhibit this work in print and electronic form publicly, or privately, and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used. My recorded image will be the only personal identifier used, otherwise my full legal name, birthdate, health insurance, and all contact information will not be included in marketing, test analysis, vestibular research, or vestibular education material for 360 Balance and Dizziness, 360 Neuro Health, and Interacoustics.

I understand that there will be no financial or other remuneration for recording me either for initial or subsequent transmission or playback. There is no expiration date to this agreement.

I represent that I have read and understand the foregoing statement and am competent to execute this agreement. Subjects under the age of 18 must have a parent or legal guardian signature.

=====

Should I refuse, my refusal will not affect my ability to obtain VNG testing, treatment, or eligibility of my insurance benefits.

CHECK HERE TO AGREE

CHECK HERE TO REFUSE

Name (Printed): _____

Signature: _____ Todays Date: ____/____/____

360 BALANCE & DIZZINESS

PATIENT REGISTRATION FORM

Date: _____

Patient Information: (Please Print)

Patient's Name: _____
First Middle Initial Last

Address: _____
City State Zip

Cell Phone: () _____ Alt. Phone () _____ Date of Birth: _____

E-mail Address: _____ Add me to the 360 Balance Mailing List: Yes No

Gender: M F _____ Preferred pronouns: _____

In case of emergency please contact: _____ Relation: _____ Phone () _____

Insurance Information See Card(s)

Insurance Primary Cardholder: (If not self) _____ D.O.B of Primary Cardholder _____

Social Security #: (If Primary Cardholder Is not self) _____ Primary Cardholder Employer: (If Applicable) _____

Employment/Work:

Work Status: Full-time Part-time Retired Disabled Other _____

Occupation: _____

If Patient is a Minor:

Legal Guardian's Name: _____
First Middle Initial Last

Address: _____
Street Address City State Zip

Cell Phone: () _____ Alt. phone: () _____

Reason for Consultation:

Reason for consultation: Dizziness Imbalance Other (please explain) _____

Onset of symptoms (date) _____ How did you hear about our clinic? _____

Are you here regarding a work related injury? yes (please fill out below) no (skip this section)

Employer _____ Employer number: () _____

Employer's Address _____
City State Zip

Physician Info:

Referring Doctor: _____ Phone: _____ Date of last visit: _____

Family Physician: _____ Phone: _____

Other Services:

Have you received physical or occupational therapy from another provider during this calendar year? Yes No

Are you currently receiving any home health services (ex. PT, OT, Speech, Nursing, etc.)? Yes No (if so, please inform front office)

HEALTH HISTORY QUESTIONNAIRE

All the information that you provide in this questionnaire is strictly confidential and will become part of your medical record.

Social/Health Habits:

- Do you smoke tobacco?** Yes No Amount/day? _____
Do you drink alcohol? Yes No Amount/week? _____
Do you use recreational drugs? Yes No Amount/week? _____
Do you exercise? Yes No Days/week? _____ Mins/day? _____

Describe exercise or activity: _____

General Health Status:

Please rate your health: Excellent Good Fair Poor Don't know

Major life Changes (past year): None Death in Family New job Divorce Move Other

Your Past Medical History:

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Meniere's Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Peripheral neuropathy |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Sleep disorder(s) |
| <input type="checkbox"/> COVID-19 | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lung disorder | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Macular degeneration | |

Please list any additional medical history:

Do you have an increase in current symptoms with hormonal changes?

- yes no

Surgical History: Please list any surgeries you have had and, if known, include dates OR see attached

Date: _____
Date: _____
Date: _____
Date: _____

Diagnostic Tests: Within the last year, have you had any of the following (check all that apply):

- | | | | |
|-------------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Angiogram | <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> Hearing test | <input type="checkbox"/> VNG or ENG |
| <input type="checkbox"/> Blood test | <input type="checkbox"/> EEG | <input type="checkbox"/> MRI | <input type="checkbox"/> Stress test |
| <input type="checkbox"/> CT scan | <input type="checkbox"/> EKG | <input type="checkbox"/> EMG/ Nerve conduction | <input type="checkbox"/> X-ray |
- Other: _____

Dizziness/Vertigo symptoms Yes No (if yes check any symptoms below that apply)

I experience dizziness (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> with turning in bed | <input type="checkbox"/> with seeing things move | <input type="checkbox"/> when bending over |
| <input type="checkbox"/> with getting into bed | <input type="checkbox"/> when I first stand up | <input type="checkbox"/> with loud noises |
| <input type="checkbox"/> with getting out of bed | <input type="checkbox"/> with moving head | <input type="checkbox"/> with coughing/sneezing/bearing down |
- Other: _____

Are dizziness symptoms: constant OR intermittent If intermittent, do symptoms last: secs mins hours days

Do you have any of the following associated with your dizzy symptoms:

- | | | | | | |
|------------------------------------|--|--|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Noise sensitivity | <input type="checkbox"/> Noises in your ears | <input type="checkbox"/> Pressure in your ears | <input type="checkbox"/> Hearing changes |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Syncope | <input type="checkbox"/> Neck pain | | |

Have you had similar symptoms in the past? Yes No, if yes describe _____

Imbalance symptoms Yes No (if yes check any symptoms below that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Imbalance when turning head | <input type="checkbox"/> Imbalance on uneven surfaces | <input type="checkbox"/> Imbalance when bending over |
| <input type="checkbox"/> Difficulty with stairs or curbs | <input type="checkbox"/> Imbalance in low lighting/dark | <input type="checkbox"/> Falls (list # of falls in last 6 months) _____ |
- Other: _____

Other symptoms- check any symptoms that you've had in the last year

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Headache | <input type="checkbox"/> Numbness in arms or legs | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Concentration problems | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Pressure in your ears | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Weakness in arms/legs |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Tinnitus (noises in your ear) | <input type="checkbox"/> Trouble swallowing or speaking |
- Other: _____

Current Medications: Please list below OR see attached

Prescription:

Medication: _____	Purpose (i.e. hypertension): _____
Medication: _____	Purpose _____
Medication: _____	Purpose _____
Medication: _____	Purpose _____
Medication: _____	Purpose _____

Non-Prescription:

Please list: _____

Allergies:

Please list: _____

Are you receiving any treatment for allergies? If yes, please describe: _____

Check here if you are not experiencing any dizziness and you can leave the rest of this page blank.

Dizziness Handicap Inventory-Screening version (DHI-S)

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please place a check in the appropriate column for “yes,” “no,” or “sometimes” for each question. Answer each question as it pertains to your current dizziness or unsteadiness problem only.

		Y	N	S
		-4	0	-2
E1.	Because of your symptoms, do you feel depressed?	___	___	___
P2.	Does walking increase your symptoms?	___	___	___
E3.	Because of your symptoms, is it difficult to concentrate?	___	___	___
F4.	Because of your symptoms, is it difficult for you to walk around your house in the dark?	___	___	___
P5.	Does bending over increase your symptoms?	___	___	___
F6.	Because of your symptoms, do you restrict your travel for business or recreation?	___	___	___
F7.	Do your symptoms interfere with your job or household responsibilities?	___	___	___
E8.	Because of your symptoms, are you afraid to leave your home without having someone with you?	___	___	___
E9.	Because of your symptoms, have you ever been embarrassed in front of others?	___	___	___
F10.	Do your symptoms significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing or to parties?	___	___	___
				Total Score: _____